Supreme Court, U.S.
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In The
Supreme Court of The United States
October Term 1997

DONALD HUTTON,
Personal Representative of
the Estate of Erric Hutton,
Petitioner,

v.

THREE RIVERS AREA HOSPITAL,
Respondent.

Petition For A Writ Of Certiorari
To The United States Court of
Appeals For The Sixth Circuit

PETITION FOR WRIT OF CERTIORARI
With Appendix

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QUESTIONS PRESENTED

This petition questions the correct interpretation of "an appropriate medical screening examination" as required by the Emergency Medical Treatment and Active Labor Act (*EMTALA)*, 42 USCA 1395dd. Three definitions of that phrase have been proposed. The Sixth Circuit Court of Appeals held in this case that Petitioner must prove that Respondent hospital acted with an improper motive. The 4th, 8th, 10th and D.C. Circuit Courts have rejected that standard, but have required Petitioner to prove that the hospital violated it owns standards. The 1st Circuit, while rejecting the term "negligence", has held that the screening exam must be "reasonable".

LIST OF PARTIES

The Petitioner is Donald Hutton, Personal Representative of the Estate of Erric Hutton. The Respondent is Three Rivers Area Hospital.

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IN THE
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DONALD HUTTON,
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v.

THREE RIVERS AREA HOSPITAL,

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On Petition for A Writ of Certiorari
To The United States Court of Appeals
For The Sixth Circuit

PETITION FOR WRIT OF CERTIORARI

Donald Hutton petitions for A Writ of Certiorari to review the Judgment of the United States Court of Appeals For The Sixth Circuit

OPINIONS BELOW

The opinions of the United States Court of Appeals for the Sixth Circuit filed on November 1, 1996 (Appendix D-16) and December 9, 1996 (Appendix E-18) were not published. The orders of the United States District Court for the Western District of Michigan, Southern Division, filed on May 11, 1995 (Appendix A-1) and October 2, 1995 (Appendix B-3) were also not published.

JURISDICTION

The final order of the Court of Appeals was entered on December 9, 1996 (Appendix E-18).

The jurisdiction of this Court is invoked under 28 USC Sec 1254(1).

The provisions of Federal Law involved herein involve 42 USCA sec 1395dd(a) which provides as follows:

> (a) Medical screening requirement
> In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the

hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency departments, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.

STATEMENT OF THE CASE

Decedent Erric Hutton was 20 years old in March 1994. On March 9, 1994, he underwent surgery in Kalamazoo, Michigan for a chronic bowel problem. He was discharged from the hospital on March 17, 1994. At 09:30 on March 21, 1994, he presented to Respondent Three Rivers Area Hospital with a pulmonary embolism. He had collapsed at home, and was found at the hospital to have chest pain, shortness of breath, low oxygen saturation, anxiety, and an abnormal EKG. The emergency room chart stated "Rule out pulmonary embolism". At 12:20 p.m. he was discharged and sent home. Late that evening he again collapsed at home, and died from a pulmonary embolism. Petitioner's Complaint alleges that the Emergency Room physician, Nicholas Nomicos, M.D., discharged Erric without performing a ventilation perfusion scan which is the standard screening exam used at Three Rivers Area Hospital and emergency rooms generally to diagnose a pulmonary embolism. Dr. Nomicos was fired following the incident.

Petitioner alleges that Respondent Hospital failed to provide an appropriate screening exam by the standards of either the medical profession or Respondent hospital. There is no reason, however, to believe that Respondent had a malicious motive. At the hearing on May 11, 1995, the District Court ruled that Petitioner's Complaint was

defective because it alleged no improper motive for Respondent's mistreatment of Erric Hutton. (Appendix C-7, C-14). In so ruling, the District Court relied on the authority of Cleland v Bronson Health Care Group, 917 F2d 266 (6th Cir 1990).

At the hearing on May 11, 1995, the District Court also granted Petitioner an opportunity to file an Amended Complaint. Petitioner filed that Complaint alleging age discrimination, and submitted interrogatories regarding that issue. Respondent's Answers to those interrogatories satisfied Petitioner that there was no age discrimination and Petitioner therefore agreed to voluntarily dismiss the Amended Complaint.

The issue before this Court is therefore simply and clearly drawn. Is the 6th Circuit correct that screening exams that violate both medical standards and the Respondent Hospital's own standards are still "appropriate" if there is no malicious motive?

ARGUMENT

I. EMTALA requires an appropriate screening examination of all emergency room patients.

The EMTALA statute, 42 USC 1395dd, provides the following:

> 1. A hospital must provide an appropriate screening examination of all emergency room patients.
>
> 2. If the hospital violates the requirements of the Act, an individual who suffers personal harm may bring a civil action for damages, and the Secretary of Health and Human Services may impose a civil money penalty of not more than $50,000 against a hospital or physician who negligently violates the Act.

In Cleland v Bronson Health Care Group, 917 F2d 266 (6th Cir 1990) the Court held that the 1986 version of the statute could not be negligently violated. The Court came to that conclusion through a judicial definition of the meaning of "appropriate". According to the Cleland Court, "appropriate" is "one of the most wonderful weasel words in the dictionary" with no ascertainable meaning. Id page 271. The court was therefore free to give the statute any

meaning it wished, and it chose a definition that reduced the statute to a nullity. According to Cleland, a screening examination would only be inappropriate if the hospital deliberately provided a substandard exam because of a malicious or improper motive. By focusing on a malicious motive, the Cleland Court required an intentional violation of the Act, and rejected Plaintiff's argument that there could be a negligent violation. According to the Cleland Court, an improper motive could include a substandard medical screening because of indigency, race, sex, politics, etc.

There is no allegation or evidence of improper motive in this case. The Emergency Room physician, Dr. Nomicos, was not malicious. He was incompetent. He had little training or experience in emergency medicine, and should not have been placed in charge of an emergency room. It is to the Hospital's credit that he was terminated following this incident. But he did not act from an improper motive. Nor is there any question that the Hospital had the capacity to screen for a pulmonary embolism. Dr. Nomicos admitted, and the Hospital's own records confirm, that the Ventilation Perfusion (V.Q.) scan is the standard screening test for a pulmonary embolism, and that V.Q. scans were available at Three Rivers Hospital.

EMTALA originated because of concern that hospitals were "dumping" indigent patients. The statute is

not restricted to indigent patients, however. Section 1395dd(a) specifically applies to "any individual (whether or not eligible for benefits under this subchapter)."

Congress specifically stated that the requirement for an appropriate screening exam applies to all patients and not just to those indigents whom the hospital might have motivation to dump. Because the statute specifically rejects restricting the statute to cases motivated by indigency, the Cleland holding that the statute is triggered only by improper motives becomes all the more unexplainable and untenable. It is little short of a defiant refusal to apply the statute to "any individual" as the language of the statute expressly requires. It is therefore not surprising that every other Circuit Court that has analyzed this statute has rejected the Cleland analysis. Correa v Hospital San Francisco, 69 F3d 1184 (1st Cir 1995) cert denied __US__, 116 SCt 1423, 134 LEd 2d 547; Power v Arlington Hospital Association, 42 F3d 851 (4th Cir 1994); Collins v DePaul Hospital, 963 F2d 303 (10th Cir 1992); Gatewood v Washington Health Care Corp., 933 F2d 1037, 1041 (D.C. Cir 1991).

> "In this respect, we depart from the reasoning of Cleland v Bronson Health Care Group, Inc., 917 F2d 266, 272 (6th Cir. 1990), which would require some showing of improper motivation, not necessarily involving indigency or lack of insurance, but

> including other improper reasons, for example, race, sex, drunkenness, or personal prejudice. We believe that any of these showings would suffice to make out a case of inappropriate screening, but we cannot agree that such evidence of improper motivation is essential. Again, **the statute contains no such requirement, and every court of appeals, with the exception of the Cleland court, which has addressed the issue, has rejected the proposition that improper motive must be shown.** Summers v Baptist Medical Center Arkadelphia, 91 F3d 1132, 1138 (8th Cir. In Banc 1996) (emphasis added)."

While rejecting the 6th Circuit's standard of motive as a requirement of the statute, most other circuits have adopted a completely idiosyncratic definition of "appropriate":

> "It is up to the hospital itself to determine what its screening procedures will be." Summers, supra pg 1138.

Under this interpretation each individual hospital is allowed to define for itself how the statute will be applied. Some hospitals may adopt standards more rigid than the medical standard of care. Other hospitals may adopt standards far below the standard of care. Only the 1st

Circuit in Correa has adopted a standard that can be objectively determined:

> "A hospital fulfills its statutory duty to screen patients in its emergency room if it provides for a screening examination reasonably calculated to identify critical medical conditions that may be afflicting symptomatic patients and provides that level of screening uniformly to all those who present substantially similar complaints." Correa, supra, pg 1192 (emphasis added).

II. EMTALA does not require malicious motive or a deliberate violation of the screening exam requirement.

There are two requirements in the statute. Subsection (a) requires an "appropriate medical screening examination." Subsection (b) requires treatment or transfer if the hospital "determines that the individual has an emergency medical condition."

Subsection (b) clearly requires knowledge. It only applies if a hospital first determines that an emergency condition exists. So the statute is not, as some suggest, simply a substitute for malpractice. If a hospital does an appropriate screening exam, but fails to properly diagnose, it might be liable for malpractice, but it would not violate

EMTALA.

But does subsection (a) also require intent? Cleland said it does, but on what basis? There is nothing in the language of subsection (a) that refers to knowledge. There is nothing in subsection (a) that requires a hospital to first determine what it believes to be an appropriate exam. Quite obviously Congress knew how to insert such language if it wanted. It did so in subsection (b). Under the penalty provisions of the original 1986 statute Congress also provided in subsection (d)(2) for a $50,000 penalty for any "participating hospital that knowingly (changed to negligently in 1990) violates a requirement of this section..." (emphasis added). Congress knew how to require knowledge when that was intended. The fact that Congress did not write a knowledge requirement into the appropriate screening subsection (subsection (a)) is a strong indication that this requirement could be violated without knowledge or improper motive.

III. The 1990 Amendments to EMTALA removed any doubt that the statute can be negligently violated.

If the original statute was not clear enough, the 1990 Amendments (Appendix F-28) changed the standard for a civil money penalty under subsection (d)(1)(A) from "knowingly violates" to "negligently violates", and also adds a civil money penalty of up to $50,000 against:

> any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section.... 42 USC 1395dd(d)(1)(B) (emphasis added).

There is simply no way to reconcile this revised language with the old Cleland requirement of improper motive. An improper motive is not negligence, and negligence is not predicated on improper motive. If Cleland is correct that only an improper motive violates the statute then there would be no way to have a negligent violation as the 1990 Amendment provides.

IV. Cleland is inconsistent with the history, language, and purpose of the statute.

There are other inconsistencies between Cleland and the statute as well. Cleland would require a motive based not on indigency, but on race, sex, politics, etc. This makes no sense at all in the context of the history and purpose of the statute. The statute was enacted because of concern over the dumping of indigent patients. There is no indication that Congress ever considered dumping based on race, sex, or politics to be a problem. If a statute enacted to protect indigents specifically states that it is not

restricted to discrimination against indigents, it makes no sense to believe that Congress wanted to restrict its application to discrimination based on race, sex or politics without ever using those words. Why would Congress try to prohibit racial, sexual, or political discrimination in a statute that was never even remotely related to those problems? If that were the Congressional intent, it would say so. But here there is nothing. It may or may not have been preferable for Congress to write a statute prohibiting such discrimination, but there is nothing in the language or history of this statute to support that interpretation. The only guidance Congress gives is that it applies to "any individual (whether or not eligible for benefits under this subchapter)." 42 USC 1395dd(a) (emphasis added).

The Cleland opinion is entirely constructed on a tortured definition of "appropriate". The Cleland Court held that what is "appropriate" is not what is medically appropriate by a malpractice or objective standard, but rather what is morally appropriate. It is a test of motives rather than competence.

The Cleland definition of "appropriate" in subsection (a) is also inconsistent with the use of the word in other parts of the statute. Subsection (c)(2)(C) defines an "appropriate" transfer as one "effected through qualified personnel and transportation equipment as required including the use of necessary and medically appropriate life support measures...". (Emphasis added). It is not

logical to believe that Congress used appropriate to mean two different things in the same statute. If Cleland were correct we would evaluate "appropriate" screening exams based on what is morally appropriate, and "appropriate" transfers based on what is medically appropriate.

Likewise, if an emergency condition is determined, subsection (b)(1)(A) requires "such further medical examination and such treatment as may be required to stabilize this medical condition." (emphasis added). If Cleland is correct the initial screening exam may be completely inadequate by medical standards, but thereafter all further exams and transfers would be based on what is medically appropriate and required. There is no reason to believe that Congress intended such inconsistent standards and definitions within the same statute. It is much more logical and consistent with both the history and language of the statute to believe that Congress was trying to require minimally acceptable medical standards rather than moral standards.

V. EMTALA can only be effectively enforced under an objective or negligence standard.

The 4th, 8th, 10th and D.C.Circuits have rejected the Cleland requirement for improper motive, but have allowed hospitals to set their own standards for screening exams. These courts would allow each hospital to

determine for itself what is "appropriate" under the statute. Summers, Powers, Collins and Gatewood, supra. In these jurisdictions hospitals are only liable for failing to follow their own standards, however inadequate from an objective on medical viewpoint, but motive is irrelevant. Although this interpretation of the statute is more reasonable than Cleland, it still makes the statute impossible to enforce, and ignores the language, history and purpose of EMTALA.

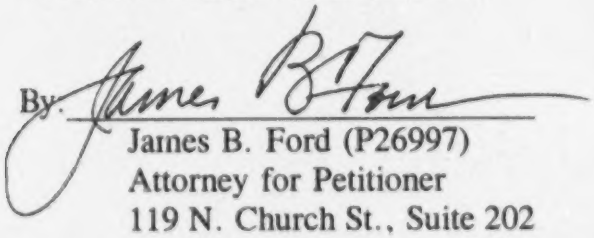
An objective standard under EMTALA does not simply duplicate malpractice law. They may overlap, but they are different. Many state laws do not require physicians or hospitals to treat anyone. In those states EMTALA may be the only available remedy. EMTALA was designed not only to require emergency screening exams, but also to specify that they must meet the minimal acceptable standards for the profession. They must be "appropriate". They must, as the 1st Circuit Stated in Correa, supra, be "reasonably calculated to identify critical medical conditions". Anything less is meaningless and unenforceable. Objective medical standards can be determined. Motives usually cannot. A hospital's own standards usually cannot. An EMTALA plaintiff has no idea how other patients are treated. He cannot subpoena records because they are privileged under both physician/patient privilege and peer review privilege. The present case is unusual in that the Respondent Hospital did violate its own written guidelines for screening for a

pulmonary embolism. In most cases the only evidence is the hospital staff's own testimony, and they will always testify that an exam met their standards. To require proof of discrimination or violation of a hospital's own standards effectively nullifies the statute. With rare exception the only cases that could be pursued would be those in which someone at the hospital is foolish enough to express a discriminatory motive. Certainly Congress intended more than a toothless and unenforceable policy statement.

CONCLUSION

There is no basis under either the history or language of EMTALA to predicate liability on an improper discriminatory motive. The holding in Cleland is inconsistent with the indigent dumping problem that prompted the statute. It is inconsistent with the references in the statute to "negligence" and "medically appropriate". It is inconsistent with penalties for negligence in the 1990 Amendment. It is inconsistent with any meaningful enforcement and it is inconsistent with the statutory interpretation of at least five other circuits. The conflict among the circuits should be resolved, and the meaning of "appropriate" should be defined in a manner that is consistent, reasonable, objective, and enforceable. The decision of the 6th Circuit should therefore be reversed, and this case should be remanded for trial.

FORD & KOBAYASHI, P.C.

By: 

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APPENDIX A

UNITED STATES DISTRICT COURT
FOR THE
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

ORDER

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

DONALD HUTTON, Personal Representative of the Estate of Erric Hutton	)	
	)	Case No.
Plaintiff,	)	4:94-CV-183
v.	)	HON. GORDON J. QUIST
THREE RIVERS AREA HOSPITAL,	)	
Defendant.	)	

ORDER

In accordance with this Court's oral Opinion issued from the Bench on May 11, 1995,

IT IS HEREBY ORDERED that defendant's Motion To Dismiss For Failure To State A Claim (docket no. 8) is **GRANTED.**

IT IS FURTHER ORDERED that plaintiff may file an amended complaint within thirty (30) days of the date of this order.

IT IS FURTHER ORDERED that defendant's Motion For Rule 11 Sanctions (docket No. 15) is **DENIED.**

IT IS FURTHER ORDERED that no discovery occur until plaintiff has filed an amended complaint. All pending discovery motions are held in abeyance until plaintiff files an amended complaint.

/s/ Gordon J. Quist
GORDON J. QUIST
UNITED STATES DISTRICT JUDGE

Dated: May 11, 1995

APPENDIX B

UNITED STATES DISTRICT COURT
FOR THE
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

STIPULATION AND ORDER OF DISMISSAL

STATE OF MICHIGAN
IN THE UNITED STATES DISTRICT COURT
WESTERN DIVISION OF MICHIGAN

DONALD HUTTON, Personal Representative of the Estate of Erric Hutton	)	
	)	Case No.
Plaintiff,	)	4:94-CV-183
v.	)	HON. GORDON J. QUIST
THREE RIVERS AREA HOSPITAL,	)	
Defendant.	)	

_____/

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STIPULATION AND ORDER OF DISMISSAL

The parties hereby stipulate that Plaintiff's First Amended Complaint may be dismissed without prejudice subject to Plaintiff's right to appeal the dismissal of the original Complaint.

FORD & KOBAYASHI, P.C.

By: /s/ James B. Ford
James B. Ford (P26997)
Attorney for Plaintiff
Business Address:
119 N. Church St., Suite 202
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(616) 342-0288
Dated: September 18, 1995

SMITH, HAUGHEY, RICE & ROEGGE

By: /s/ William R. Jewell
William R. Jewell (P35675)
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Business Address:
200 Calder Plaza Building
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Dated: September 25, 1995

ORDER

At a session of the United States District Court, held in the Federal Building, in Grand Rapids, Michigan on the 2nd day of October, 1995.

PRESENT: HONORABLE GORDON J. QUIST

Pursuant to the Stipulation of the parties, Plaintiff's First Amended Complaint is dismissed without prejudice.

/s/ Gordon J. Quist
Hon. Gordon J. Quist

APPENDIX C

UNITED STATES DISTRICT COURT
FOR THE
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

TRANSCRIPT
MAY 11, 1995

Beginning Transcript, page 31

THE COURT: Yes. Thank you, Mr. Jewell.

Well, first of all, let me say I appreciate your efforts. And it's an interesting question. And to rule on the Rule 11 motion first, certainly there is nothing that in my judgment would desire -- or deserve any kind of sanctions, because I think that it is a fair attempt to either distinguish the law or to extend current precedent on the matter.

I think that, quite frankly, I'm bound by Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266 (6th Circuit, 1990.) Let me just discuss Cleland a little bit more as I go along here. And please bear with me because I'm referring to hosts of notes I've got. Once I got into this issue, I found it, quite frankly, very interesting. I don't know why, because I'm not engaged in this area of law, but here I am.

In my judgment, the construction of the statute urged by the plaintiff would broaden the scope of the Act as that Act is interpreted by Cleland and specifical ly as to the argument

that the amendment to the civil enforcement provisions which provide for a civil penalty would change the 6th Circuit's definition of "appropriate medical screening" or "emergency medical condition" -- especially appropriate medical screening.

The amendment to that particular provision, in my judgment, doesn't necessarily change the 6th Circuit's interpretation of "appropriate medical screening." In other words, I -- they did not talk about that particular provision in making their analysis of the phrase "appropriate medical screening."

I hear Mr. Ford's argument, and I think it's a good argument. But it is not one that I feel I can accept because of the analysis that the 6th Circuit afforded in Cleland. By that I mean -- by "good," I mean not one I would necessarily accept, but I think that it's an interesting argument and certainly a good argument in the sense that many arguments are good, even though you feel that you cannot accept them in a particular time.

I think under Cleland, violation of a standard may have some bearing on determining a bad motive. But I do believe that a bad motive is required by Cleland even if a standard is violated. And a violation of a standard in and of

itself does not in the 6th Circuit give rise to a claim under this specific statute in and of itself.

In other words, under Cleland, I do not think that a violation of a standard is distinct from the motive requirement of Cleland. I recognize that Gatewood v. Washington Health Care Corp., 933 F.2d 1037, 1041, Note 3 -- it's the D.C. Circuit, 1991 -- does hold that violation of the hospital's own standard is a distinct basis for a private claim under the Act.

However, in so holding, Gatewood at Footnote 3, the D.C. Circuit stated specifically that it departed from the holding in Cleland when Gatewood held that:

> "... any departure from standard screening procedures constitutes inappropriate screenng in violation of the Act. The motive for such departure is not important to this analysis, which applies whenever and for whatever reason a patient is denied the same level of care provided and guaranteed him or her by subsection 1395 dd(a)."

Thus the D.C. Circuit interprets Cleland the same way that I do; namely, that motive is an element even though a standard of care has been violated. Once again that's page

1041 of Gatewood.

The 4th Circuit in Power v. Arlington Hospital Association, 42 F.3d 851 (4th Circuit 1994) is also critical of Cleland's motive requirement. And the 4th Circuit decided to follow Gatewood. One of Powers' criticisms of Cleland is that the expansive motive suggested by Cleland is so broad as to be of no limit at all and as a practical matter amounts to not having a motive requirement.

> "Anyone who alleges that she did not receive an appropriate medical screening examination can simply find an improper motive that fits --"

After some other words, unquote. That's on pages 857 and 858.

Interestingly, Gatewood, that I mentioned earlier, upheld the dismissal of the case because there was no allegation that a defendant hospital departed from its standard emergency room procedures in treating Erric Hutton.

Quite frankly, Mr. Ford, I didn't see that in your complaint either. Is it in there?

MR. FORD: I'm sorry. That they violated their own standards?

THE COURT: Departed from its standard emergency room proceedings in treating Mr. Hutton.

MR. FORD: We really did not specify how it was inappropriate, simply that it was inappropriate.

THE COURT: Right. Okay.

Cleland, of course, also came up on a motion to dismiss as distinguished from summary judgment. And Cleland went through a list of things that the District Court relied on that were not alleged:

One. There was no indication or allegation that the care provided to the boy and the decision to discharge him were based upon anything other than the best medical judgment of those employed at the hospital.

Two. There was no allegation that the screening was in any way different than would have been offered to any other patient or was deficient in any way peculiar to the patient's characteristics.

Three. The allegation of the failure to stabilize before discharge was similarly based only on outcome.

Four. There is nothing to indicate that the patient's condition at discharge would have been considered stable for any other patient. And

Fifth. There was no allegation of any facts known to doctors at the time to imply that the young boy, the decedent, was not stabilized.

They don't re lly talk about the specific failures, but those are all things that the plaintiff failed to allege that -- and, of course, the District Court in Cleland, as I recall it, dismissed because the plaintiff failed to allege indigency or lack of insurance, which the 6th Circuit and all circuits have said are not requirements. But the 6th Circuit, at least, has said you have to have some motives. Those motives would be improper. But there are apparently limitless other motives that are required.

The 6th Circuit dismissed -- or, upheld the dismissal of the complaint in Cleland because the complaint failed to allege any inappropriateness in the medical screening in the sense required by the Act.

> "... there is not the slightest indication that this outcome would have been different for a patient of any other characteristics. Had his sex, race, national origin, financial condition, politics, social status, et cetera, been anything whatsoever, as far as can be gleaned from the complaint, the outcome would have been the same."

And once again I emphasize that they are looking at the complaint -- they are not looking at other facts -- and upholding the dismissal of the action in that particular case.

They go on and say: The term "appropriate" does not mean resort to a malpractice or other objective standard of care.

> "Instead 'appropriate' must more correctly be interpreted to refer to the motives with which the hospital acts. If it acts in the same manner as it would for the usual paying patient, then the screening provided is 'appropriate' within the meaning of the statute."

Please bear with me again.

Even Power, by the way, holds that EMTALA is not a substitute for state malpractice law and was not intended to guarantee proper diagnosis or to provide federal remedies for misdiagnosis or medical negligence. But all of those cases say that misdiagnosis after proper procedures does not create a claim under EMTALA.

Anyway, an action may be dismissed if the complaint fails to state a claim upon which relief can be granted. The moving party has the burden of proving that no claim exists. All factual allegations in the complaint must be presumed to be true, and reasonable inferences must be made in favor of the nonmoving party. Dismissal is proper only if it is clear that no relief could be granted under any set of facts that could be proved consistent with the allegations.

Dismissal is also proper if the complaint fails to allege an element necessary for relief or if an affirmative defense or other bar to relief is apparent from the face of the complaint, such as the official immunity of the defendant. Certainly, we don't have that here.

But I do think that there are some necessary elements missing, as I've said.

Number one. There is no allegation that the hospital

departed from its standard emergency room procedures in treating Erric Hutton. I cite to you Gatewood for that proposition.

Two. There is no allegation of the motive for alleged different treatment of Eric Hutton. I cite to you Cleland for that proposition.

Three. There is no allegation that the defendant hospital had knowledge that Erric Hutton was not stable when he was released. I don't think there was. Let me just double-check on that. Yes. That's correct. There was no knowledge -- no allegation that the defendant hospital had knowledge that Erric Hutton was not stable when he was released. And there is no allegation as to the motive for release while Erric Hutton was not stable.

If I haven't said it, I'll say it: In my judgment, the appropriateness is tied up in motive and not simply violation of the standard. Therefore, I'm going to grant the motion to dismiss the complaint for failure to state a claim under 12(b)(6) and give the defendant --

How much time do you want to think about filing an amended complaint, Mr. Ford?

MR. FORD: Could I have 30 days?

THE COURT: 30 days. That's a long time, but I'll give you 30 days unless there is an objection by Mr. Jewell. In the meantime I'll suspend discovery.

APPENDIX D

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

MEMORANDUM OPINION

NOT RECOMMENDED FOR PUBLICATION

No. 95-2241

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

DONALD HUTTON, PERSONAL REPRESENTATIVE OF THE ESTATE OF ERIC HUTTON,	)	
	)	ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF MICHIGAN
Plaintiff-Appellant,	)	
v.	)	
THREE RIVERS AREA HOSPITAL,	)	**MEMORANDUM OPINION**
Defendant-Appellee.	)	

BEFORE: LIVELY, BOGGS, and NORRIS, Circuit Judges.

PER CURIAM. Plaintiff, Donald Hutton, appeals the order of the district court that dismissed his lawsuit, which he had brought pursuant to the Emergency Medical Treatment and Active Labor Act. 42 U.S.C. §1395dd.

Having had the benefit of oral argument, and having carefully considered the record on appeal and the briefs of the parties, we conclude that the holding of this court in its opinion in *Cleland v. Bronson Health Care Group*, 917 F.2d 266 (6th Cir. 1990), is dispositive of the issue raised by this appeal and requires us to affirm the district court. *See United States v. Smith*, 73 F.3d 1414, 1418 (6th Cir. 1996) (a panel of this court may not overrule a prior published decision of another panel.) Accordingly, the judgment of the district court is **affirmed**.

Filed: November 1, 1996

APPENDIX E

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

ORDER

No. 95-2241

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

DONALD HUTTON, PERSONAL REPRESENTATIVE OF THE ESTATE OF ERIC HUTTON,	)	
Plaintiff-Appellant,	)	**ORDER**
v.	)	
THREE RIVERS AREA HOSPITAL,	)	
Defendant-Appellee.	)	

BEFORE: LIVELY, BOGGS, and NORRIS, Circuit Judges.

The court having received a petition for rehearing en banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this court, and no judge of this court having requested a vote on the suggestion for rehearing en banc, the petition for rehearing has been referred to the original panel.

The panel has further reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original submission and decision of the case. Accordingly, the petition is denied.

ENTERED BY ORDER OF THE COURT

/s/ Leonard Green

Leonard Green, Clerk

Filed: December 9, 1996

APPENDIX F

Statutes and Legislative History

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§1395dd. Examination and treatment for emergency medical conditions and women in active labor.

(a) Medical screening requirement

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists or to determine if the individual is in active labor (within the meaning of subsection (e)(2) of this section).

(b) Necessary stabilizing treatment for emergency medical conditions and active labor.

(1) In general

If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition or is in active labor, the hospital must provide either --

(A) within the staff and facilities available at

the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition or to provide for treatment of the labor, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.

(2) Refusal to consent to treatment

A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph but the individual (or a person acting on the individual's behalf) refuses to consent to the examination or treatment.

(3) Refusal to consent to transfer

A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) of this section but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer.

(c) Restricting transfers until patient stabilized

(1) Rule

If a patient at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(4)(B) of this section) or is in active labor,

the hospital may not transfer the patient unless --

(A) (i) the patient (or a legally responsible person acting on the patient's behalf) requests that the transfer be effected, or

(ii) a physician (within the meaning of section 1395x(r)(1) of this title), or other qualified medical personnel when a physician is not readily available in the emergency department, has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

(2) Appropriate transfer

An appropriate transfer to a medical facility is a transfer --

(A) in which the receiving facility --

(i) has available space and qualified personnel for the treatment of the patient, and

(ii) has agreed to accept transfer of the patient and to provide appropriate medical treatment;

(B) in which the transferring hospital provides the receiving facility with appropriate medical records (or

copies thereof) of the examination and treatment effected at the transferring hospital;

(C) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(D) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of patients transferred.

(d) Enforcement

(1) As requirement of medicare provider agreement

If a hospital knowingly and willfully, or negligently, fails to meet the requirements of this section, such hospital is subject to --

(A) termination of its provider agreement under this subchapter in accordance with section 1395cc(b) of this title, or

(B) at the option of the Secretary, suspension of such agreement for such period of time as the Secretary determines to be appropriate, upon reasonable notice to the hospital and to the public.

(2) Civil money penalties

(A) A participating hospital that knowingly violates a requirement of this section is subject to a civil money penalty of not more than $50,000 for each such

violation. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1320a-7a(a) of this title.

(B) The responsible physician in a participating hospital with respect to the hospital's violation of a requirement of this subsection is subject to the sanctions described in section 1395u(j)(2) of this title, except that, for purposes of this subparagraph, the civil money penalty with respect to each violation may not exceed $50,000, rather than $2,000.

(C) As used in this paragraph, the term "responsible physician" means, with respect to a hospital's violation of a requirement of this section, a physician who --

(i) is employed by, or under contract with, the participating hospital, and

(ii) acting as such an employee or under such a contract, has professional responsibility for the provision of examinations or treatments for the individual, or transfers of the individual, with respect to which the violation occurred.

(3) Civil enforcement

(A) Personal harm

Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement

of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) Financial loss to other medical facility

Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) Limitations on actions

No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(e) Definitions

In this section:

(1) The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in --

(A) placing the patient's health in serious jeopardy.

(B) serious impairment to bodily functions, or

(C) serious dysfunction of any bodily organ or part.

(2) The term "active labor" means labor at a time at which --

(A) delivery is imminent,

(B) there is inadequate time to effect safe transfer to another hospital prior to delivery, or

(C) a transfer may pose a threat of (*so in original probably should be "to"*) the health and safety of the patient or the unborn child.

(3) The term "participating hospital" means hospital that has entered into a provider agreement under section 1395cc of this title.

(4) (A) The term "to stabilize" means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from the transfer of the individual from a facility.

(B) The term "stabilized" means with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the individual from a facility.

(5) The term "transfer" means the movement (including the discharge) of a patient outside a hospital's

facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of a patient who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(f) Preemption

The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

§1395dd. Examination and treatment for emergency medical conditions and women in labor.

(a) Medical screening requirement

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.

(b) Necessary stabilizing treatment for emergency medical conditions and labor

(1) In general

If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either --

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.

(2) Refusal to consent to treatment

A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

(3) Refusal to consent to transfer

A hospital is deemed to meet the requirement

of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) of this section and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

(c) Restricting transfers until individual stabilized

(1) Rule

If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B) of this section), the hospital may not transfer the individual unless --

(A) (i) the individual (or legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to

another medical facility,

(ii) a physician (within the meaning of section 1395x(r)(1) of this title) has signed a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1395x(r)(1) of this title), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

(B) the transfer is an appropriate

transfer (within the meaning of paragraph (2)) to that facility.

A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) Appropriate transfer

An appropriate transfer to a medical facility is a transfer --

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility --

(i) has available space and qualified personnel for the treatment of the individual, and

(ii) has agreed to accept

transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), the name and address of any on-call physician (described in subsection (d)(1)(C) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life

support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) Enforcement

(1) Civil money penalties

(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1320a-7a(a) of this title.

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a

participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who --

(i) signs a certification under subsection (c)(1)(A) of this section that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,

is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this subchapter and State health care programs. The provisions of section 1320a-7a of this title (other than the first and second sentences of subsection (a) and subsection (b) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with

respect to a penalty, exclusion, or proceeding under section 1320a-7a(a) of this title.

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1395cc(a)(1)(I) of this title) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

(2) Civil enforcement

(A) Personal harm

Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the

participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) Financial loss to other medical facility.

Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) Limitations on actions

No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) Consultation with peer review organizations

In considering allegations of violations of the requirements of this section in imposing sanctions

under paragraph (1), the Secretary shall request the appropriate utilization and quality control peer review organization (with a contract under part B of subchapter XI of this chapter) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review.

(e) Definitions

In this section:

(1) The term "emergency medical condition" means --

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in --

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant women who is having contractions --

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term "participating hospital" means hospital that has entered into a provider agreement under section 1395cc of this title.

(3) (A) The term "to stabilize" means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term "stabilized" means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term "transfer" means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated,

directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(5) The term "hospital" includes a rural primary care hospital (as defined in section 1395x(mm)(1) of this title).

(f) Preemption

The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(g) Nondiscrimination

A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(h) No delay in examination or treatment

A participating hospital may not delay provision of an

appropriate, medical screening examination required under subsection (a) of this section or further medical examination and treatment required under subsection (b) of this section in order to inquire about the individual's method of payment or insurance status.

(i) Whistleblower protections

A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

(j) *Psychology Service for Inpatients*. -- The conference agreement includes the Senate amendment. The Conferees note that this section is not intended to change or override any other provision of Federal law or regulation or State law establishing the scope of practice for clinical psychologists or qualified psychologist services.

(l) *Hospital and Physician Obligations with Respect to Emergency Medical Conditions*. -- The conference agreement changes the standard of liability for civil monetary penalties for physicians from "knowingly violates a requirement" to "negligently violates a requirement." It changes the standard for excluding a physician from Medicare from a "knowing and willfull or negligent" violation of the requirements to a violation of the requirements which "is gross and flagrant or is repeated." The provision applies to actions occurring on or after the first day of the six month after enactment.

The conference agreement also includes section 4103 of the House bill with an amendment to require the consultation of the Secretary with PROs with respect to

allegations of violations of the provisions of requirements of section 1867 of the Social Security Act relating to the examination and treatment of emergency medical conditions. The provision requires the Secretary to require the appropriate PRO to review the medical condition of the individual and provide a report concerning its findings. Specifies that the PRO assess whether the individual had an emergency medical condition which had not been stabilized. The provision requires, except in the case in which a delay would jeopardize the health or safety of individuals, that the Secretary request such a review before terminating or suspending the provider from Medicare or imposing civil monetary penalties and to provide for at least 60 days for the review.

(2) *Development of Prospective Payment System for Home Health Agencies.* -- The conference agreement requires the Secretary of HHS to develop for home health care a proposal to modify or replace the current reimbursement methodology with a prospective payment system.

APPENDIX G

UNITED STATES DISTRICT COURT
FOR THE
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

COMPLAINT

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MICHIGAN

DONALD HUTTON,
Personal Representative
of the Estate of
Erric Hutton, Deceased,

Plaintiff,

Case No.
4:94-CV-183

v.

HON. GORDON J. QUIST
U.S. District Judge

THREE RIVERS AREA
HOSPITAL,

Defendant.
_____/

JAMES B. FORD (P26997)
Attorney for Plaintiff
FORD & KOBAYASHI, P.C.
119 N. Church St., Suite 202
Kalamazoo, MI 49007
(616) 342-0288
_____/

THERE IS NO OTHER CIVIL ACTION BETWEEN THESE PARTIES ARISING OUT OF THE SAME TRANSACTION OR OCCURRENCE AS ALLEGED IN THIS COMPLAINT PENDING IN THIS COURT, NOR HAS ANY SUCH ACTION BEEN PREVIOUSLY FILED AND DISMISSED OR TRANSFERRED AFTER HAVING

BEEN ASSIGNED TO A JUDGE, NOR DO I KNOW OF ANY OTHER CIVIL ACTION, NOT BETWEEN THESE PARTIES, ARISING OUT OF THE SAME TRANSACTION OR OCCURRENCE AS ALLEGED IN THIS COMPLAINT THAT IS EITHER PENDING OR WAS PREVIOUSLY FILED AND DISMISSED, TRANSFERRED, OR OTHERWISE DISPOSED OF AFTER HAVING BEEN ASSIGNED TO A JUDGE IN THIS COURT.

COMPLAINT

For his Complaint against Defendant, Plaintiff alleges the following:

1. Jurisdiction of this Court is based upon a federal question pursuant to 42 USC, Section 1395(dd).

2. On March 20, 1994 decedent Erric Hutton was admitted to Defendant Three Rivers Area Hospital emergency room with complaints and symptoms consistent with a pulmonary embolism.

3. While Erric was a patient at the emergency room, Defendant failed to provide for an appropriate medical screening examination to determine whether or not an emergency medical condition existed.

4. After determining that an emergency medical condition did exist, Defendant failed to stabilize the medical condition, and failed to transfer Erric to another medical facility for further medical examination and such treatment as may be required to stabilize the medical condition, including but not limited to the following:

a. Performing a ventilation perfusion scan.

b. Providing examination and treatment by a cardiologist or pulmonologist.

c. Administering Heparin.

d. Administering Streptokinase or TPA.

e. Inserting an IVC filter.

f. Providing adequate adjunctive therapy such as oxygen, anti-inflammatory agents, and ventilatory assistance.

5. As a direct and proximate result of Defendant's failure to provide either adequate screening or a transfer to other available hospitals, Erric Hutton, his estate, and his heirs have suffered multiple pulmonary emboli, physical pain and suffering, emotional distress, death, and the loss of Erric's love and companionship.

WHEREFORE, Plaintiff demands judgment for whatever amount he is found to be entitled plus costs, interest, punitive damages, and reasonable attorney fees.

FORD & KOBAYASHI, P.C.

By: /s/ James B. Ford
James B. Ford (P26997)
Attorney for Plaintiff

Dated: November 4, 1994

(2)

Supreme Court, U.S.
FILED
APR 25 1997
OFFICE OF THE CLERK

No. 96-1426

In The

Supreme Court of the United States

October Term, 1996

DONALD HUTTON, Personal Representative of the Estate of Erric Hutton,

Petitioner,

vs.

THREE RIVERS AREA HOSPITAL,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

RESPONDENT'S BRIEF IN OPPOSITION

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28 pp

QUESTION PRESENTED FOR REVIEW

The petitioner's petition asks the Court to review and reverse the Sixth Circuit's interpretation of "appropriate medical screening examination" as used in the Emergency Medical Treatment Act (EMTALA), 42 U.S.C. § 1395dd. The Sixth Circuit holds that "appropriate" means "care similar to care provided to any other patient." It says that a screening examination that is not appropriate is one that is "deficient in any way peculiar to the patient's characteristics," including, but not limited to, the patient's "sex, race, national origin, financial condition, politics, social status." The Sixth Circuit holds, then, that the petitioner must show a screening examination was inadequate as a result of improper discriminatory motive, not negligence. The petitioner contends, on the other hand, that "appropriate" should be interpreted so that it is measured by a negligence standard, thereby making the federal law duplicate state medical malpractice law.

LIST OF PARTIES

The petitioner is Donald Hutton, Personal Representative of the Estate of Erric Hutton. The respondent is Three Rivers Area Hospital.

Three Rivers Area Hospital has no parent or subsidiary companies.

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Preventing Patient Dumping: Sharpening the COBRA's Fangs, 61 N.Y.U. L. Rev. 1186 (1986)	3

OPINIONS BELOW

The opinions and orders of the United States Court of Appeals for the Sixth Circuit were entered on November 1, 1996 and December 9, 1996. Neither was published. They are included as D-16 and E-18 in the Petitioner's Appendix. The opinions and orders of the United States District Court for the Western District of Michigan, Southern Division, were filed on May 11, 1995, and October 2, 1995. Neither of those was published. They are included as A-1 and B-3 in the petitioner's appendix.

STATEMENT OF JURISDICTION

The statement of jurisdiction contained in the petitioner's petition is complete and correct.

STATEMENT OF THE CASE

The petitioner's decedent, Erric Hutton, underwent surgery in Kalamazoo on March 9, 1994, for a chronic bowel problem. He was discharged from the Hospital on March 17. He presented at the emergency room of the respondent, Three Rivers Hospital, on March 21, 1994, complaining of chest pain and shortness of breath. He was examined, treated and discharged. Later that evening he died from a pulmonary embolism.

The petitioner, personal representative of his estate, has brought this action seeking damages under 42 U.S.C. § 1395dd. He claims the emergency room physician was negligent for not having administered a test which would have determined that Mr. Hutton was suffering a pulmonary embolism.

The respondent moved for summary disposition in the District Court for the reason that the petitioner's complaint

alleged only negligent care, but not that it was improperly motivated. The respondent relied upon the Sixth Circuit's prior interpretation of the statute in *Cleland v. Bronson Health Care Group*, 917 F.2d 266 (6th Cir. 1990). The District Court held that *Cleland* does control, and that dismissal on the pleadings was appropriate. The court allowed the petitioner, however, to amend his complaint to allege a discriminatory motive. The petitioner did so by including allegations of age discrimination (Erric was 20) in the amended complaint.

The petitioner later agreed to dismissal of the amended complaint for the reason that there was no evidence at all of age discrimination or any other improper motive. The petitioner appealed to the Sixth Circuit where he claimed that *Cleland* was incorrectly decided or that it is no longer valid, given certain amendments to other provisions of the statute. He argued that his original complaint was sufficient to state a cause of action under 42 U.S.C. § 1395dd. The Sixth Circuit rejected the petitioner's arguments and affirmed the decision of the District Court for the reason that the matter was controlled by its prior decision in *Cleland*. The court also denied the petitioner's motion for rehearing en banc.

REASONS FOR DENYING THE WRIT

I.

42 U.S.C. § 1395dd IS INAPPLICABLE TO THIS CASE, GIVEN THAT IT WAS NEVER INTENDED TO CREATE, NOR DID IT CREATE, A FEDERAL CAUSE OF ACTION FOR MEDICAL MALPRACTICE.

A. Introduction.

Accepting the petitioner's allegations at face value and construing them in the light most favorable to him, the complaint

states a common law negligence claim against the Hospital. The question here is whether these allegations also support a federal statutory claim, which will, in essence, duplicate the state law medical malpractice claim.

The respondent contends that Congress never meant for EMTALA to create a federal action for ordinary medical malpractice claims. The Sixth Circuit agrees and first did so beginning in 1990 in *Cleland, supra*. *Cleland* says that a plaintiff bringing a claim under 42 U.S.C. § 1395dd must prove that alleged substandard medical care resulted from a discriminatory or other improper motive, to distinguish the federal claim from ordinary negligence claims.

The petitioner in this case alleges that Dr. Nomicos did not give competent care, but the petitioner does not claim that Dr. Nomicos had any improper motive. As discussed below, the Sixth Circuit has properly interpreted EMTALA, and the petitioner's allegations of negligence alone will not support a claim under the federal statute.

B. Congress Intended 42 U.S.C. § 1395dd To Prohibit The Practice Of "Patient Dumping".

The phenomenon known as "patient dumping" occurs when a hospital capable of providing necessary medical care either transfers a patient to another facility or simply turns the patient away because the patient is unable to pay. The practice existed because the expense of treating uninsured patients creates economic incentive to "dump" them elsewhere, generally on public hospitals which must then care for the majority of uninsured patients.[1]

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1. *See Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. Rev. 1186 (1986); *Patient Dumping in the Hospital Emergency Department: Renewed Interest in an Old Problem*, 13 Am. J. Law & Medicine 561 (Fall-Winter 1988).

42 U.S.C. § 1395dd, EMTALA's anti-dumping provisions, represent Congress' response to nationwide concern over the problem of patient dumping.[2] Section 1395dd requires, as a condition of participation in Medicare, that hospitals with emergency departments must provide "appropriate medical screening" of all patients seeking emergency care, regardless of the patient's ability to pay, to determine if an "emergency medical condition" exists.

If an "emergency medical condition" is detected, the hospital must treat the patient until the condition is "stabilized," meaning that no material deterioration of the condition is likely to result from the patient's transfer from the facility. 42 U.S.C. § 1395dd(e)(3)(A). If the patient has an "emergency medical condition" which has not been "stabilized" within the meaning of EMTALA, an "appropriate transfer" of the patient is permitted under certain limited conditions.

Significantly, if a hospital determines that the patient does not have an "emergency medical condition," EMTALA does not apply, and the hospital is free to transfer or discharge the patient.

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2. H.R. Rep. No. 241, 99th Cong., 1st Sess., Pt. 1, at 27, reprinted in 1986 U.S. Code Cong. & Admin. News 579, at 605:

> The [House Committee on Ways and Means] is greatly concerned about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance. The Committee is most concerned that medically unstable patients are not being treated appropriately. There have been reports of situations where treatment was simply not provided. In numerous other instances, patients in an unstable condition have been transferred improperly, sometimes without the consent of the receiving hospital.

That is, if the emergency nature of a condition is not detected or ascertained despite an appropriate screening, the hospital cannot be charged with failure to stabilize a known emergency condition under EMTALA.[3] Further, even if the hospital finds an "emergency medical condition," EMTALA no longer applies, and the hospital may discharge or transfer the patient as it sees fit, once the patient is "stabilized."[4]

EMTALA provides a variety of enforcement mechanisms. A hospital may have its provider contract with Medicare suspended or terminated if it "knowingly and willfully, or negligently" violates the statute. § 1395dd(d)(1). A violating hospital may also be subject to civil monetary penalties for knowing or negligent violations. § 1395dd(d)(2)(A). Finally, EMTALA grants standing to an individual suffering personal harm from an EMTALA violation to bring a federal civil cause of action against the violating hospital. § 1395dd(d)(3).

C. The Plaintiff Seeks To Misapply 42 U.S.C. § 1395dd To A Claim That Is Essentially One Of Medical Malpractice.

Th petitioner attempts to apply § 1395dd to the factual situation in this case, but § 1395dd was not intended to be a vehicle for a federal medical malpractice wrongful death action. Congress would not approve such a use, because that would distort the statute's intended purpose as evidenced by its legislative history.

It is easy to see why the statute is so appealing from a plaintiff's perspective. The plaintiff would like to use the statute as a means of bypassing state tort reform measures. The

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3. *Cleland v. Bronson Health Care Group*, 917 F.2d 266, 271 (6th Cir. 1990).

4. *Cleland*, at 271.

American Bar Association Journal noted a number of years ago that that plaintiffs' attorneys were filing EMTALA suits, instead of malpractice actions, because the federal statute permits injunctive relief; it makes the hospital the primary defendant instead of the doctor, thereby increasing the chance of tapping a "deep pocket;" and because it allows a plaintiff to establish liability by mere proof of a violation.[5]

D. A Cognizable Cause Of Action Under § 1395dd Requires Pleading A Discriminatory Or Other Improper Motive In The Hospital's Treatment, And In the Absence Of Such Allegations, Dismissal Is Proper.

The Sixth Circuit, in *Cleland v. Bronson Health Care Group*, 917 F.2d 266 (6th Cir. 1990), meticulously reviewed EMTALA's legislative history and interpreted its statutory terms and duties to require pleading and proof of a *discriminatory motive* on the part of any hospital sued under the statute. Its ruling that "discriminatory motive" is an essential element of an EMTALA claim has consistently been applied within the Sixth Circuit. *See, e.g., Hines v. Adair County Public Hospital District Corp*, 827 F. Supp. 426, 431-433 (W.D. Ky. 1993); *Tolton v. American Biodyne, Inc.*, 854 F. Supp. 505, 511 (N.D. Ohio 1993).

More specifically, *Cleland* interprets "appropriate" medical screening examination to mean "care similar to care provided to any other patient." *Cleland*, at 271. Accordingly, an inappropriate screening examination is one that is "deficient in any way peculiar to the patient's characteristics," *Id.*, at 269, including, but not limited to, the patient's "sex, race, national origin, financial condition, politics, social status." *Id.*, at 271. The *Cleland* analysis, at 271, states as follows:

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5. *ABA Journal*, November 11, 1988, pp. 17-18.

"Appropriate" is one of the most wonderful weasel words in the dictionary, and a great aid to the resolution of disputed issues in the drafting of legislation. Who, after all, can be found to stand up for "inappropriate" treatment or actions of any sort. **Under the circumstances of the act, "appropriate" can be taken to mean care similar to care that would have been provided to any other patient, or at least not known by the providers to be insufficient or below their own standards.** Plaintiffs essentially contend that "appropriate" denotes, at a minimum, the full panoply of state malpractice law, and at a maximum, includes a guarantee of successful result.

In one sense, in hindsight, the screening provided in this case could scarcely be called appropriate. The patient came in, he had a condition that was at least conceivably ascertainable by medical science, the condition was not ascertained, and he died within 24 hours. At the same time, **there is not the slightest indication that this outcome would have been any different for a patient of any other characteristics. Had his sex, race, national origin, financial condition, politics, social status, etc., been anything whatsoever, as far as can be gleaned from the complaint, the outcome would have been the same. Under these circumstances, we hold that the complaint simply fails to allege any inappropriateness**

> **in the medical screening in the sense required by the Act.** [Emphasis added].

Similarly, with respect to the statutory duty to "stabilize," prior to transfer or discharge (which, of necessity, only arises where a physician actually discovers an emergency condition during the course of a screening exam), *Cleland* again has ruled that a breach of the duty to stabilize requires pleading and proof of a discriminatory motive:

> The same reasoning applies to stabilization, though with even greater force. To all appearances, the plaintiff's condition was stable. He was not in acute distress, neither the doctors nor the patient or his parents made the slightest indication that the condition was worsening in any way, or that it presented any risk that might become life-threatening, or that it would worsen markedly by the next day.
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> Again, in hindsight, any stability was quite short-run. The patient died. However, neither the normal meaning of stabilization, nor any of the attendant legislative history or apparatus, indicates that Congress intended to provide a guarantee of the result of emergency room treatment and discharge. In the hospital's opinion, the patient was stable, and they would have believed that a patient with any differing characteristics would have been stable. We therefore hold that within the meaning of the Act, the hospital did its duty to stabilize young Cleland, and there are no allegations in the

> complaint to the contrary. Therefore, dismissal under Rule 12(b)(6) is proper.

Cleland, 271.

The petitioner's fixation upon negligence in this case "cannot cloud the otherwise clear distinctions between claims under common law negligence and EMTALA's statutory causes of action." *Hines*, *supra*, at 434. As the court in *Hines* said, at 431-432:

> The Sixth Circuit noted that nothing within the statutory language or legislative history "indicates that Congress intended to provide a guarantee of the result of emergency room treatment and discharge." [*Cleland* at 271]. In other words, **Congress did not intend to create a federal tort of negligence or to require the application of a negligence standard in an analysis of either of these federal duties as an alternative to state medical malpractice claims.** [Emphasis added].

Indeed, there was no reason for Congress to have some special concern for malpractice in the emergency room setting that would justify a federal tort of emergency room negligence. That is properly the subject of state tort law and very adequately redressed in that setting. Congressional concern was with "patient dumping" caused by discriminatory motive, and nothing more. In short, given the obvious legislative intent, the statutory EMTALA action requires pleading and proof that the respondent Hospital had a discriminatory motive.

E. The Petitioner Concedes That There Was No Discriminatory Or Improper Motive In This Case.

The petitioner concedes there is nothing in this case to indicate that Dr. Nomicos had any discriminatory or improper motive. Consequently, comparing this case to *Cleland*, "there [is] no indication or allegation [or basis for inferring] that the care provided to [Erric Hutton], and the decision to discharge him were based on anything other than the best medical judgment of those employed by the hospital." *Cleland*, at 269. "There is no allegation that the screening was in any way different than would have been offered to any other patient, or was deficient in any way peculiar to the patient's characteristics." *Id.* "The allegation of 'failure to stabilize' before discharge is similarly based only on the outcome." *Id.* The petitioner "point[s] to nothing that indicates that the patient's condition at discharge would not have been considered stable for any other patient, nor is there any allegation of any facts known to the doctors at the time to imply that the patient was not stabilized." *Id.* In short, while the petitioner's complaint might state a traditional medical malpractice wrongful death claim under state law, it does not satisfy the prerequisites for stating a valid claim under EMTALA.

Finally, dismissal of the EMTALA claim does *not* leave petitioner without a remedy:

> It would require a cold heart indeed not to feel sympathy for the unfortunate and probably preventable circumstances which befell Plaintiff . . . The sequence of events and ultimate consequences must have been like a nightmare for Plaintiff. Indeed, Plaintiff has carefully set these facts as the centerpiece of his case. However, Plaintiff's

> fixation upon negligence misunderstands the federal duties imposed by [§]1395dd. The Court's natural sympathy for Plaintiff cannot cloud the otherwise clear distinctions between claims under common law negligence and EMTALA's statutory causes of action. Moreover, this result does not leave Plaintiff without a remedy, but merely limits the jurisdiction of the federal courts to consider his particular complaint. *Hines*, at 434.

The petitioner, were it not for recent tort reform measures in Michigan, would never have filed this claim in the Federal Court. The petitioner must not be allowed to make a strained and unintended use of EMTALA as a means of circumventing the proper avenue of remedy, state tort law. The Sixth Circuit has prohibited that misuse of EMTALA, and there is no reason for this Court to conclude that the Sixth Circuit did not interpret the statute properly.

II.

THE DECISIONS OF OTHER CIRCUITS WHICH DEPART FROM THE *CLELAND* ANALYSIS HAVE MADE SEMANTIC DISTINCTIONS THAT, IN PRACTICAL APPLICATION, MAKE LITTLE OR NO DIFFERENCE.

The petitioner points to decisions from the First, Fourth, Tenth, and DC Circuits which have departed from *Cleland's* conclusion that an inappropriate medical screening is one which has departed from the norm due to some improper motive directed toward the individual patient. In truth, these decisions do not depart greatly from *Cleland*.

Cleland says that an "appropriate" medical screening evaluation is one which does not depart from the care provided to any other patient. *Cleland* also concluded that EMTALA was not meant to be federal cause of action for medical malpractice. The decisions of the other Circuits are fully consistent with *Cleland's* conclusions on both of those counts.

The Sixth Circuit, recognizing that EMTALA was not meant to be a federal cause of action for medical malpractice, went on in *Cleland* to show how negligence is carved out of the definition. Obviously, whenever a plaintiff claims negligent screening and evaluation, he or she is claiming to have had a screening examination which has departed from the care normally provided to oth.. patients. If the alleged inadequate screening has resulted from negligence alone, however, *Cleland* and the decisions from other Circuits say that the claim does not come within the purview of the federal statute.

The *Cleland* court recognized that it needed to exclude situations resulting from negligence alone, and negligence is a state of mind. Consequently, the distinction that must be made concerns the medical provider's state of mind. Turning to state of mind, the *Cleland* court said that the question is not whether the screening examination was negligently performed, but whether it was refused, or less than provided normally, on account of some intentional discriminatory motive peculiar to the individual patient. In short, *Cleland* makes good sense, because it goes through the full analysis needed to distinguish EMTALA from ordinary state law medical malpractice claims.

The other Circuits which have said that they will not look to motive as a measure of "appropriate" have usually done so anyway. One of the best examples is the fairly recent decision of the Eighth Circuit in *Summers v. Baptist Medical Center Arkadelphia*, 91 F.3d 1132 (8th Cir. 1996). In that case, the

plaintiff had taken a fall from a tree, and he appeared at the emergency room complaining of pain and popping noises in his chest. He was examined and discharged but was not given a chest x-ray. He suffered complications as a result of a medical condition which would have been revealed by a chest x-ray. He claimed EMTALA violations for inadequate screening, alleging that any other patient presenting with his symptoms would have been given a chest x-ray.

The Eighth Circuit said that they would not look to improper motive as the test for adequacy of the screening evaluation, but they also rejected the plaintiff's EMTALA claim saying:

> The important point for us is that the very respect in which the plaintiff's screening is said to be non-uniform — failure to order a chest x-ray for a patient complaining of popping noises in his chest — is nothing more than an accusation of negligence. We accept for purposes of this appeal from a summary judgment the proposition that Summers in fact made this complaint, and that the doctor did not hear him, or forgot what had been said. (There is no contention that the doctor deliberately failed to order a chest x-ray.) This may have been medical malpractice, but if it is also an EMTALA violation, that statute has been converted into a federal cause of action for a vast range of claims of medical negligence. It would always be possible to characterize negligence in the screening process as non-uniform treatment, because any hospital's screening process will presumably include a non-negligent response to symptoms or

> complaints presented by a patient. To construe EMTALA this expansively would be inconsistent with the principles and cases set out earlier in this opinion.

Summers, 1138-1139.

The Eighth Circuit, despite its statement to the contrary, was looking to motive. It said that the plaintiff was accusing the hospital of nothing more than "negligence." It said that there was no contention the doctor had "deliberately" failed to order the chest x-ray. In the discussion which follows this quote, however, the court said that it focused on what the doctor "perceived" to be the plaintiff's medical condition. It said there was no EMTALA violation if the doctor provided care similar to care he would give to others with the same "perceived" condition. *Summers*, 1139.

Unfortunately, this last part of the Eighth Circuit's reasoning was flawed because it was entirely circular. The plaintiff in such cases is claiming that the doctor has misperceived a condition as the result of inappropriate screening and evaluation, not vice versa.

The Eighth Circuit should have stuck to its focus on motive. As it concluded, EMTALA is not meant to be a federal action for medical negligence. The only real distinction that keeps EMTALA from being a duplicate of state negligence law is that drawn by the Sixth Circuit in *Cleland*, and that requires a focus on motive. There is no good reason to upset that view of the statute.

III.

1990 AMENDMENTS TO EMTALA'S MEDICARE PROVIDER PARTICIPATION AND CIVIL PENALTY SANCTION PROVISION HAVE NOT UNDERMINED THE RATIONALE OF THE *CLELAND* DECISION.

The petitioner argues that the 1990 amendments to EMTALA have rendered *Cleland* obsolete and no longer controlling. The petitioner asserts, erroneously, that amendment of the standards applicable to EMTALA's civil penalty and Medicare provider sanctions automatically altered the standards applicable to EMTALA's civil action sanction.

The amended sanctions are separate and distinct enforcement mechanisms from the civil action sanction at issue in this case. The civil action sanction was not amended. *Cleland*, like the case at bar, involved a private civil action by a patient against a hospital under EMTALA's "civil action" enforcement provision, 42 U.S.C. § 1395dd(d)(3)(A). Again, this provision was not changed in any way by the 1990 amendments.

The 1990 amendments relied upon by plaintiff modified EMTALA's "Medicare provider agreement" sanction [42 U.S.C. § 1395dd(d)(1), as originally enacted] and "civil penalty" sanction [42 U.S.C. § 1395dd(d)(2), as originally enacted]. The petitioner in this case is not proceeding under either of those sanction provisions, nor was the plaintiff in *Cleland*, for the simple reason that neither of those sanction provisions create a private civil cause of action available to injured patients.

Under the 1988 version of § 1395dd(d), four separate and distinct enforcement mechanisms were available to redress a violation of EMTALA's requirements (only one of which was available to private plaintiffs):

(1) termination or suspension of the hospital's Medicare provider agreement by HHS for "knowingly and willfully, or negligently" failing to meet EMTALA's requirements. This enforcement mechanism is administered by and imposed at the initiative of the Secretary of Health and Human Services ("HHS"), and is not available to private plaintiffs. [*See Deberry v. Sherman Hosp. Ass'n.*, 775 F. Supp. 1159 (N.D. Ill. 1991)];

(2) a hospital was subject to a civil monetary penalty of up to $50,000 for each knowing EMTALA violation. This enforcement mechanism is enforceable only by the Federal government or one of its agencies, not by private plaintiffs. [*See Holcomb v. Monahan*, 807 F. Supp. 1526 (M.D. Ala. 1992)];

(3) a private civil cause of action against the hospital by a patient harmed as a direct result of the hospital's EMTALA violation. This is the *only* sanction available to private plaintiffs; and

(4) if a patient was transferred to a receiving hospital in violation of EMTALA, a suit by the receiving hospital against the transferring hospital for its financial loss as a result of the "patient dumping."

In 1990 [Pub. L. 101-508], Congress amended EMTALA's Medicare participation and civil penalty sanction provisions, because it wanted to clarify the standards applicable to those specific remedies.[6] The 1990 amendments changed the standard for imposing civil monetary penalties against participating

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6. H.R. Conf. Rep. No. 964, 101st Cong., 2nd Sess. 1990, reprinted in 1990 U.S.C.C.A.N. 2017, 2421.

Medicare hospitals from "knowingly" to "negligently" violating an EMTALA requirement. Again, the civil penalty and Medicare provider sanctions affected by the amendments [formerly § 1395dd(d)(1)&(2), now § 1395dd(d)(1)(A)&(B)] are not now and have never been available to private plaintiffs. EMTALA's private civil action enforcement mechanism for individuals personally harmed as a direct result of a participating hospital's violation of EMTALA [formerly § 1395dd(d)(3)(A), now § 1395dd(d)(2)(A)] was not amended in any respect, and the standards applicable to such private civil actions, as set forth in *Cleland*, remain in full force and effect and unchanged.[7]

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7. The sanction provisions, as amended in 1990, are set forth below, in pertinent part, for ease of reference:

(d) Enforcement.

(1) Civil money penalties.

(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation . . .

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who --

(ii) signs a certification under subsection (C)(1)(A) of this section that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician

(Cont'd)

(Cont'd)

knew or should have known that the benefits did not outweigh the risks, or

(iii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,

is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this subchapter and State health care programs. . . .

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1395cc(A)(1)(I) of this title) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

(2) Civil enforcement

(A) Personal harm *Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal*

(Cont'd)

The 1990 amendments did not substantively change EMTALA's provision regarding the medical screening requirement [§ 1395dd(a)], which originally and still refers only to "an appropriate medical screening examination within the capability of the hospital's emergency department," except to explain that "capability" includes "ancillary services routinely available to the emergency department." The 1990 amendments did not substantively change EMTALA's provision regarding "necessary stabilization treatment" [§ 1395dd(b)(1)]. Because those terms are not specifically defined by the statute (and never have been). *Cleland*'s interpretation of those key statutory terms is still valid in cases premised on the civil action sanction provisions of the statute.

CONCLUSION

The petitioner has attempted to bring this straightforward medical malpractice case in the Federal Court under the provisions of EMTALA. The petitioner has done so in an effort to circumvent Michigan tort reform law, which he views as more restrictive than might be the remedy in Federal Court if he has a viable EMTALA claim.

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> *injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate* [Emphasis added].
>
> **(B) Financial loss to another medical facility** Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

The Sixth Circuit holds that 42 U.S.C. § 1395dd was not intended by Congress to establish a federal tort action for medical malpractice. Congress meant the statute to address the problem of "patient dumping," a practice employed by some medical providers to avoid the financial consequences of treating patients who are without means to pay.

The Sixth Circuit's decision in *Cleland* interpreted § 1395dd in a manner consistent with that purpose. Thus, to make a viable EMTALA claim, the plaintiff must show "inappropriate" emergency screening or stabilization resulting from a discriminatory or improper motive (because the patient is unable to pay, or on account of race or sex, for example). The petitioner acknowledges here that there was no discriminatory or other improper motive on the part of the medical providers. He bases this EMTALA claim solely on allegations of incompetent care. That claim must proceed, if at all, under state tort law. It is not a proper EMTALA claim.

The petitioner argues *Cleland* is no longer valid given the 1990 amendments to EMTALA, but that argument is without merit. The amendments are to other provisions of EMTALA. There was no amendment of the provision under which the petitioner seeks to proceed in this case. Consequently, the Court's interpretation in *Cleland* of the provision at issue in this case remains unaffected. Congress did not change the language pertaining to the petitioner's claim here of "inappropriate" medical screening and failure to stabilize. The petitioner must still prove improper motive as the essence of this federal action. He admits that there is no evidence of improper motive.

The respondent asks, therefore, that petitioner's Petition for Writ of Certiorari be denied, and that the respondent be awarded its costs and fees incurred in this matter.

Respectfully submitted,

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